Emergency Involuntary Procedures (EIP) Work Group
Department of Mental Health
280 State Drive, NOB 2 North
Waterbury, VT 05671-2010
June 12, 2020 ~ 10:30am – 12:00pm

Attendance [phone]: DMH Staff: David Horton, Chris Donnelly, Frank Reed, Karen Barber, Jennifer Rowell; VAHHS: Emma Harrigan; Windham Center, Gina Piccione; CVMS:, Terri Graham; NAMI,: Laurie Emerson; UVMMC,, Katie Ruff; VCPI, Karen Crowley; VPCH: Scott Perry and Jeremy Smith; RRMC:, Lesa Cathcart; VPS: Michael Sabourin; DAIL, Sarah Sherbrook; BR, Beth Harmon.

Welcome and Introduction: Introductions took place over the phone.

Six Core Strategies: When we met last, we were just beginning to talk about the fact that scope of work and activities as planned might need to be revised due to everyone being remote. We have now put together a series of 4 virtual training sessions. Invites have gone out for this. Doing intensive work with BR and VPCH for individualized technical assistance. We have funds for this from now until the end of August to do activities.

Data Review – David Horton and Chris Donnelly

Pages 3,4,5 as a group – all broken down by aggregate procedures [different populations]

Page 3 [adults], page 4 [youth], page 5 [all psychiatric units], type of procedure by month. There has been an increase in youth from the last report, but in line with previous reports from August, September, and October. Manual restraint is most commonly used in the youth psych units.

Page 6 – same data, presented longitudinally in a line graph, each color line is a different EIP. Downward trend for manual restrains overall as well as seclusion. Emergency medication trend upward ever so slightly since last quarter as well as mechanical restraints.

Questions: Why do we only track EIP on Involuntary patients? – The EIP rule applies only to individuals on inpatient units; that is the charge of this committee.

Page 7 – same data broken out by not only type but the units they were issued on.

Page 8 - aggregate EIPs broken out by counting the procedures for each patients. The vast majority of adult patients did not receive any EIPS in the last quarter, most non-level 1 received 4 or less.

Page 9 – by episode, most patients received EIPs with a small number of episodes

Question: Can you go back and talk about episodes verses procedures – how are those attributed? Definition of this is listed on page 2 of the EIP report.

Page 10 and 11 go together and break out EIPs on level 1 units, on the bottom of page 10 seeing standards represented as a red line.

Page 11 – EIP rate of seclusion and restraint on level 1-unit, same data broken out in a line graph. Level 1 units VPCH and RRMC declined, BR T4 saw an increase from last quarter to this quarter.

Page 12 – all 3 below the national average

Presentation – Windham Center

10 bed DMH designated unit, which is free standing from the main hospital in Bellows Falls. We are currently closed to admissions due to renovations, with a plan to reopen July 15th tentatively. Under renovations for several reason, older building, not up to regulatory standards for behavioral health. We also were approached by DMH and have contracted with them to become a designated COVID-19 positive behavioral health hospital. When we reopen, we can accept COVID-19 positive patients. There are many moving parts to that. Because we are 10 beds and servicing all other hospitals, if patients appears in an ED in another facility and test positive for COVID-19, they would be transferred to us. Went to tele -psych in March due to COVID-19 and might keep that when open again. Have had support from VPCH and DMH for intensive trainings for EIP procedures and the legal aspects of that. Never had EIP in about 7 years, so we have taken the opportunity to beef up staff and training which have been doing really well.

Patients would be asymptomatic to mild, someone that was higher than that, would be managed at the respective facility. Reworked staffing matrix to almost doubling staff that we have due to the potential acuity. We have looked at our courtyard area, we have an 8-foot fence, would go to a 12-foot climb proof fence. Major changes to the structure of the building and would get behavioral furniture that we did not always have.

Presentation – VPCH

VPCH is the State's hospital, 25 bed secure facility, divided into subunits. Before COVID-19 we were most of the time close to full capacity, we are not now. We are using the two 8 bed units for our hospitalized units and the 5 bed unit is being utilized for the residents of MTCR. 4 bed does not have patients at this time.

The nursing supervisors, night shift prepare a 24-hour report which summarizes the number of major points on each patient in the facility, updated every day and distributed to all clinical staff and leadership every morning. This has been extremely helpful, incudes EIPs, high risk events, etc. That is followed [emailed] at 7:45 morning brief for all clinical staff and leaders are welcome via Skye. The day shift nursing supervisor reviews hot spots and plans for the day.

Lots of procedures for reviewing EIPs. We have multiple filtering processes that are intended to ensure nothing gets missed. We also process for trends and patterns. The 3 months being reviewed, did not have any significant clinical challenges that stood out above all others. We do have restraint chairs, and have developed a PowerPoint to train the nuances and major points on how to safely use the restraint chair, hopefully to reduce the use of mechanical restraints in bed, etc.

We started using ProAct at VSH after we were part of the first 6CS grant. It has been very effective for us. Not always easily accepted by staff but it has become deeply encultured in our system now. It is all about reducing the use of seclusion and restraint and we are quite committed to that.

Our CEO brought to the hospital a few years ago a direct care staff driven safety council which is truly a shared governance approach. Now that they are really in place, if there is anything that effects the physical environment or social environment of the patient care area, any change/modification is vetted through the safety council before the changes are made. They have developed methods of accessing potential risks of any changes.

They do scenario based drills on de-escalation, where actors and actresses [staff] act out scenarios, semi-out of control emotional situational and staff members are given an opportunity to practice dealing with the actor/patient and then receive real time feedback on the spot. It has been extremely helpful in raising the sophistication level of direct care staff and grows team work.

Question – The 4 point chair, have you totally eliminated the other restraints? No, we are still using the other standard EIPs but it takes a while to train 100 or so staff to new behaviors in emergency situations. We are wanting to do this very thoughtfully. The trainings are ready, in a nice PowerPoint with photos and FAQs. We are loading that into the

LMS and all direct care will be required to complete the training before we start utilizing the chairs on the units. We are right on the edge of implementing that.

Question - Is that a best practice with other hospitals? It protects the persons being restrained, much more protective of autonomy, sitting up right eye to eye, not spread-eagle on a bed. It is definitely a step up in terms of response and respect and the care and protection of the persons dignity.

RRMC has had the chair for several years. There are not a lot of restraints anymore, but we have found this a much more dignified way to restrain patients. We also do a crisis assessment if they need to be restrained, they generally say they prefer the chair, and the feedback after being restrained, was it is a much more dignified way to be restrained.

BR agrees with both of those statements. They have been using the chair as primary method for about 1.5 years, what a difference to be able to sit across from folks to look them in the eye, not laying in a bed. The de-escalation happens much quicker.

Annual Report

This report is due in August of this year. Karen Crowley will send out a copy of the report from last year and would be a good place to start. Think about things over the next couple of weeks to address in the report either via phone or email.

- Going back to the statute and looking at the people on the advisory committee and ensuring there is that representation and wanted to follow up on that. Looking at getting someone with lived experience, do we have that? Let NAMI know if you need help reaching out to people.
- Lack of reporting in EDs and voluntary patients – committee could have a recommendation to consider those venues for reporting through Legislation.
- Good sharing best practices, allow for a good discussion to share what everyone is doing.
- Standards on different units, different expectations produce different results.

Public Comments

No public comment